Reasons contributing to low uptake of HIV testing and counselling services by health workers in Masvingo urban district

by

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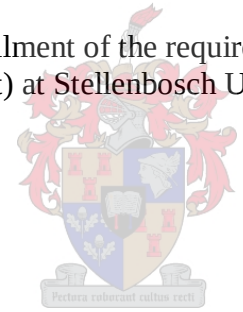
Assignment presented in partial fulfillment of the requirements for the degree Master of Philosophy (HIV/AIDS Management) at Stellenbosch University



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ABSTRACT

HIV and AIDS have not spurred the health professionals despite the fact that the society expects health workers to be role models and have adequate knowledge of HIV and AIDS. This study wanted to identify the gaps that exist in the health workers' knowledge, skills and attitude in the practice of HIV Testing and Counselling services. The limitation was that the study was conducted at three workplace in Masvingo Urban District and cannot be generalised for the health professionals.

The findings showed that the health workers have knowledge on HIV and AIDS and have relatively high level of uptake of HIV Testing and Counselling services and they know where to access the services. The recommendations are that there is need for continuous in-service education for health workers to be updated, need to explore additional barriers to HIV Testing and Counselling uptake, stigma at workplace and need to assure confidentiality so that health workers can access HIV testing and Counselling services freely. Health workers should be at the forefront of undergoing HIV Testing and Counselling, and explaining the benefits and advantages to the communities they operate in.

OPSOMMING

Die doel van hierdie studie was die bepaling van die kennisgaping asook verskille in houdings en vaardigheid van gesondheidswerkers wat verantwoordelik is vir MIV voorligting en toetsing. Die studie is by drie werkplekke in die Masvingo stedelike distrik gedoen en daar kan uiteraard nie veralgemeen word ten opsigte van die bevindings nie.

Resultate het aangetoon dat die kennisvlakke van gesondheidswerkers relatief hoog is; dat hulle gereeld vir toetsing en voorligting aanmeld en dat hulle weet waar sodanige dienste beskikbaar is.

Daar word in die studie voorgestel dat daar volgehou word met in-diens opleiding van gesondheidswerkers en dat hierdie opleiding selfs opgeskerp word. Gesondheidswerkers behoort baie gereeld voorligting en toetsing te ondergaan sodat hulle eerstehands die voordele van voorligting en toetsing aan ander lede van die gemeenskap kan verduidelik en die noodsaaklikheid daarvan kan uitspel.

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1. Introduction

This chapter discusses the overview of HIV and AIDS epidemic, HIV testing and counselling, evolution of HIV Testing and Counselling in Zimbabwe, Impact of HIV and AIDS to Health workers, research problem, research question, and significance of study aims and objectives of the study.

1.2 Background of study

1.2.1 Overview of HIV/AIDS Epidemic

Globally in 2009 a total of 33, 3 million people were living with Human immunodeficiency virus (HIV) and there were 2,6 million were new infections of HIV. Two thirds of the infection is found in the Sub-Saharan Africa and Zimbabwe is included. Zimbabwe is a land locked country with a population of about 12 million people. It is surrounded by Zambia on the North, South Africa on the South, Botswana on the East and Mozambique on the West. In 2009 Zimbabwe had a total of 1,102,864 people living with HIV and of which 997 123 are adults and 594 847 being adult females (54% coverage) (ZNASP II 2011-2015 draft). The main route of transmission in Zimbabwe is sex (92%) then Mother to child transmission (7%) and exposure to infected body fluids (1%).The major HIV Key drivers of Zimbabwe's epidemic include multiple concurrent partnerships, low and inconsistent levels condom us, low rates of male circumcision and age disparity sexual relationship.(ZNASPII 2011-2015 draft). The life expectancy in most countries has gone down to between 30 years and 35 years with the exception of SA which has about 42years.Zimbabwe uses the Zimbabwe demographic Health Survey and the Antenatal Sentinel Surveillance to come up with the prevalence rate. Zimbabwe has had a steady decline of HIV prevalence from 23% in 2003 to 13,6% in 2009 and the decline has been attributed to the prevention programmes like Behaviour Change Communication(BCC), Prevention of mother to child transmission (PMTCT) , migration to other countries due to economic hardships, mortality and fear. The first HIV case was seen in Zimbabwe in 1984 at Harare Central Hospital though literature shows that the virus was present in Africa as early as 1900. HIV-1 is predominant in Zimbabwe and few cases of HIV-2. HIV uses other cells to survive and reproduce. HIV is a retrovirus that uses its RNA and the Host DNA to replicate.

1.2.2 HIV Testing and Counselling

HIV Testing and Counselling (HTC) has proved to be one of the most powerful weapons in halting the spread of HIV / AIDS. HTC is the process whereby an individual or couple undergo counselling to enable them to make an informed choice about being tested. The decision must be entirely the choice of the individuals and they must be assured that the process will be confidential. Knowing one's HIV status and being able to discuss it with trained professionals induces sustainable positive behaviour change in both infected and uninfected. This intervention also facilitates access to prevention services for negative people and is a key entry point to care and support services for those who are HIV infected. This includes access to interventions to reduce Parent to Child transmission of HIV, intervention to prevent opportunistic infections and other medical and supportive services that can help HIV positive people to live longer and live healthy lives and an entry point to active case finding of Tuberculosis. Masvingo Urban District is in Masvingo Province and It has one Private Clinic, three council clinics and one Masvingo Provincial Hospital which is a training Hospital for State Registered Nurses and State Certified Midwives.

1.2.3 Evolution of HIV Testing and Counselling in Zimbabwe

In Zimbabwe HIV Testing and Counselling (HTC) started in 1994 with routine screening of donated blood and blood products at National Blood Transfusion Services of Zimbabwe NBTSZ. HTC was available in clinical setting by 1991, Voluntary Counselling and Testing (VCT) was first introduced in Bulawayo town and in 1999 Ministry of Health and Child Welfare (MOHCW) partnered with Population Services International Zimbabwe (PSI-Z) to scale up HTC services under the New Start Franchise programme whose network has expanded country wide. The New Start brand is promoted using proven social marketing techniques to increase demand and reduce stigma around the use of HTC services. The New Start Network celebrated testing one million clients in year 2007 and two million clients in 2010. The success of the New Start project in Zimbabwe inspired similar activities in Haiti, Angola, Benin, Botswana, India, Kenya, Kosovo, Mali, Mozambique, Namibia, Rwanda, Togo, Uganda, Swaziland, Zambia and recently South Africa (USAID Health 2004). In year 2005 the MOHCW adopted the Opt Out approach. HTC is an important entry point to HIV prevention services which are Prevention of Mother to Child Transmission (PMTCT), Antiretroviral (ART), Dual protection, Male Circumcision(MC) and Social and Behaviour Change Communication(SBCC) . HTC contributes to the reduction of HIV stigma and

discrimination when people go public about their HIV status though Sambisa, W (2008) says HIV related stigma and discrimination acts as a significant impediment to utilisation of HTC services. Zimbabwe has two models of HTC, 1. Client Initiated approach (VCT), 2. Provider initiated approach (PITC) and is guided by three principles of confidentiality, counselling, and consent and requires client consent except for Mandatory HIV screening. Zimbabwe adopted the serial algorithm in 2010 with bigger laboratories doing Elisa test and smaller centres doing rapid HIV test which provide results after 20 minutes. HTC requires a lot of human and material resources for it to be implemented.

1.2.4 Impact of HIV/AIDS to Health workers

According to the Zimbabwe Human Development Report (ZDHR) (2003) on discharge register for referral hospital in Harare, the number of staff deaths progressively increased from 75 in 1993 to 250 in year 2000. More men than women were discharged on medical grounds or died during the same period. According to the ZHDR 2003 one health institute with an establishment of about 120 lost 15 of its employees through death between 1992 and 2002. Ten of the employees that died had typical symptoms of AIDS at the time of their death. Almost half of the deaths were among scientists and senior Laboratory technicians. Tuberculosis outbreak among health staff was reported in Chiredzi district in Masvingo province in 2000. The same district recorded the highest HIV prevalence among pregnant women in the same year (MOHCW 2000). This could be indirect evidence that HIV prevalence was also very high among health staff. Deployment of nursing staff without due consideration working locations of their spouses was cited as an important determinant of risky behaviour. This contravenes the provisions in Guiding Principles 5 of the Zimbabwe AIDS Policy that seeks to uphold marital integrity and sustainability. For young nurses deployed in remote areas risky sexual relationships were reportedly common particularly with extension workers who had access to cars and came often to their areas of operation.

1.3 Researchproblem

Health professionals are supposed to be role models when it comes to HIV / AIDS issues. Although there are no figures on the extent of HIV infection among health workers, it is evident that the health sector is no less affected than the general population. This is despite the fact that the sector was the coordinator of the national response of HIV / AIDS until the establishment of National Aids Council in 1999. The society expects that health workers have adequate knowledge about HIV / AIDS and they see the devastating effects the disease

has on health. Health workers who are motivated and who know their HIV status are able to implement HIV/AIDS programmes effectively. Nurses take a leading role on Provider Initiated Testing and Counselling which was introduced in Zimbabwe in 2007 and 1560 health centres are providing the service. This study intends to establish whether gaps exist in health workers knowledge, skills and attitude in their practice in relation to HTC services.

1.4 Research Question

The research question of this study waswhat are the reasons contributing to low uptake of HIV Testing and Counselling (HTC) services by health workers in Masvingo Urban District?

1.5 Significance of the study

The knowledge gap which the study seeks to address is we do not know why there is a low uptake of HTC by health workers in Masvingo Urban District. I am working as a Site Manager for Population Services International (PSI) Zimbabwe managing HTC site. We refer clients who have tested HIV positive to go and access OI /ART services to Masvingo Provincial Hospital, Private hospital and Council Clinics. My study is going to benefit my employer PSI-Zimbabwe and Ministry of Health and Child Welfare as follows,

- The body of knowledge generated could enhance PSI-Z practice through integration of new knowledge into training and in-service programmes for employees and community and stakeholders.
- Increase the uptake of our HTC services by health workers because they are going to encourage each other as well as the community more people to know their HIV status.
- Health workers are in a strategic position of care and support to work as change agents, by adopting a positive attitude towards HTC they are going to receive clients which we refer to them for care and support with a positive attitude thereby improving service delivery and they also influence behaviour change.
- Our referral tracking system is going to be strengthened and this also improves our statistics and show that work is being done.
- Improvement of the quality of services which we provide at our HTC site.
- It will provide information for further research on topic.

The body of knowledge generated could enhance health sector practice to come up with appropriate programmes targeting health workers, integration of new knowledge into training curriculum of health professionals and in-service programmes in Zimbabwe.

1.6Aim

The aim of the study was todetermine the reasons for the low uptake of HTC services by health workers in Masvingo Urban District in order to come up with appropriate interventions.

1.7 Objectives

Objectives of the study can be summarised as follows,

- To identify the HTC services available to health workers in Masvingo Urban District.
- To identify the reasons contributing to low uptake of HTC services by health workers in Masvingo Urban District.
- To establish the knowledge of health workers in Masvingo Urban District on HTC.
- To identify the barriers to HTC services to health workers.

CHAPTER.2. LITERATURE REVIEW

Introduction

The general purpose for literature review is to gain an understanding of the current state of knowledge about the topic selected. (Christensen 2011). This chapter covers the literature related to the study on the theoretical perspective of the study, previous studies done on HTC and Zimbabwe National response to HIV and AIDS epidemic.

2.0 Theoretical Perspectives of the Study

2.0.1 Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) by Ajzen 1991 is going to be used in the study. It is about the link between attitudes and behaviour and is an extension of the Theory of Reasoned Action (TRA) which was proposed by Martin Fishben and Icek Ajzen in 1975. The TRA has theories of learning, expectancy, value, consistence and attribution. TRA says if people evaluated the suggested behaviour as positive (attitude), and if they think their significant others want them to perform the behaviour (subjective norm), this results in higher intention (motivation) and they are likely to do so. A high correlation of attitudes and subjective norms to behavioural intention, and subsequently to behaviour has been confirmed in other studies (Sheppard et al 1988). Ajzen TPB added perceived behaviour control. Perceived behavioural control was therefore added on a level with attitude and subjective norms as a predictor of intention so as to measure persons' perceived ability to perform a particular behaviour in different situations (Ajzen,1991). The TPB is also an extension of Self- efficacy Theory (SET) proposed by Bandura in 1977 which came from the social cognitive theory. Given sufficient degree of actual control over the behaviour, people are expected to carry out their intentions when the opportunity arises (Ajzen, 2002b). The TPB is mostly widely tested and validated model in the prediction of health behaviours in different social cultural contexts (Godin and Kok 1996). The TPB has been useful in predicting condom use in behaviour in Tanzanian (Lugoe and Rise 1999), Ghana (Bosompra 2001) and Zimbabwe (Wilson, Zenda, McMaster and Lavelle, 1992. In Tanzania Kakoko., used it in a study on Voluntary HIV Counselling and Testing service uptake among school teachers and he added the Perceived HIV/AIDS risk component to the TPB.

2.0.2 Health Belief Model

Health Belief Model is a psychological model that attempts to explain and predict health behaviours with focus on attitudes and beliefs of individuals. It was developed in 1950s and updated in the 1980s to explain the lack of public participation in health screening and prevention programmes. There was need for explanation on why Medical screening for Tuberculosis were not very successful (Hochboum, 1958). It is based on the person's willingness to change their health behaviours and has four stages which are as follows,

Perceived seriousness: This is when an individual belief about seriousness of a disease. Something minor can be serious to another individual.

Perceived Susceptibility: When people believe that they are at risk they will change their health behaviour e.g. use of condoms to prevent HIV and STIs.

Perceived Benefits: People will change their behaviours if they see that they will get something out of it.

Perceived Barriers: This and individual's own evaluation of obstacles which can hinder him from adopting new behaviours.

The two elements of cues to action and self efficacy have been incorporated.

2.0.3AIDS Risk Reduction Model

AIDS Risk Reduction Model (ARRM) was introduced in 1990. It is a three stage model which provides a framework for explaining and predicting the behaviour change efforts specifically in relationship to sexual transmission of HIV/AIDS. The ARRM has three stages which are as follows,

1. Recognition and labelling of one's behaviour as high risk.

2. Making a commitment to reduce high risk sexual contact and to increase low risk activities.

3. Taking action where there is information seeking, obtaining remedies and enacting solutions.

Health workers have information on HIVAIDS and STIs and they give information to the public and they are expected to practice what they say but it looks like they have been heavily

impacted by the HIV/AIDS pandemic. The health workers use the above theories when dealing with clients in assisting them on behaviour change process.

2.1 Previous Studies Done

In Zimbabwe not many studies have been done on Health workers related to HTC services. Regai Dzive Shiri Project 2004-2007 in Zimbabwe did a study which showed that women accessed HTC services at rural health centres while men and youth were not comfortable and when HTC was offered at non clinic, the number men and women who went for HTC was similar. This also suggested that health workers have confidentiality and attitude problems which shun away clients. The ZINASP II 2011-2015 clearly documented that stigma is also prevalent among health care providers in health care settings which has compromised uptake of HIV/AIDS services.Tarwireyi and Majoko in 2003 in Zimbabwe did a descriptive cross sections survey on health workers which revealed that 87.4% had not gone for voluntary HTC, 77% did not want to have the HIV test with reasons being not ready, not have coverage to go, no need since HIV cannot be cured, not being able to cope with results and some needed counselling before accessing HTC. Studies done by Smit 2005, Walusimbi and Okonsky 2004 showed that nurses had fear and anxiety of occupational exposure to HIV infection. A study done by Hara 2007 on attitudes and perceptions of student nurses towards Voluntary HTC showed that there are barriers like fear of HIV result, stigma and lack of understanding of Voluntary HTC process. In Tanzania Kakoko, did a study on Voluntary HIV Counselling and testing services uptake among primary school teachers. He used the Theory of planned behaviour, Theory of Health seeking behaviour and HIV/AIDS related stigma as an anticipated discrediting phenomenon in 2006 (date). The study identified socio-demographic, psychosocial and social-cognitive factors that are important in promoting VCT service uptake among primary school teachers in Tanzania. Tawfik. and Kinoti 2006 did a study which concluded that health workers should be treated as an essential and vital national resource, especially in the current state of the HIV/AIDS epidemic. Obiajulu (2008)'s study on knowledge attitudes and practice of VCT among health professionals showed that they understand the importance of VCT but there remains some VCT knowledge attitude and practice that needs to be addressed. The above findings from studies are some of the contributing factors of why health workers are not accessing voluntary HTC services.

2.2 National Responses to HIV/AIDS Epidemic

The Government of Zimbabwe (GOZ) has continued to scale up the multisectoral response to HIV/AIDS (ZNASP 2006-2010). HIV/AIDS is national emergency where GOZ and stakeholders pulled together resources to fight the epidemic being guided by the Strategic Plan with the National AIDS Council coordinating the activities. There has been political commitment from the parliamentarians. Zimbabwe does not have the HIV prevention Strategy and the National Behavioural Change Strategy(NBCS) 2006-2010 has accelerated the country's goal to reduce HIV prevalence to less than 10% by 2010 in line with the Millennium Development Goal (Zimbabwe Country report 2008 to 2010) The NBCS was launched in year 2007 in 26 district of the country and the programme was rolled out to the other remaining 36 districts in year 2010. This has led to the increase in utilisation of HIV prevention services such as HTC, PMTCT, Post Exposure Prophylaxis and post test support. Blood safety has been maintained by the National Blood Service of Zimbabwe (NBSZ) an independent non profit organisation whose mandate is collection and distribution of blood and blood products in the country. In year 2005 NBSZ developed guideline document "Prescribing blood" and attained ISO Certification in year 2007.Anteretroviral(ART) programme was rolled out in April 2004 and Plan for Nationwide Provision of ART was finalised in December 2002 covering period 2005-2007(MOHCW 2004).ART coverage increased from 5000 to 215 109 in November 2009. Paediatric ART was scaled up and ART has been decentralised to district level. ART policy has been supported by International NGOs, Local NGOs, Individual Private Donors and GOZ though funding gaps have been a hindrance in achieving Universal access to ART. PMTCThas been a success, there has been an increased uptake of PMTCT by pregnant women and PMTCT protocols were amended in 2008.Early infant diagnosis was introduced in 2008 using the HIV DNA PCR testing at the National Medical Reference Laboratory. Tuberculosis (TB) and HIV collaborative activities have been strengthened with the support of Global Fund though there is a challenge on lack of diagnostic services for TB. HTC is the entry point to care and support services, the GOZ launched the Zimbabwe National HIV Testing and Counselling Strategic Plan 2008-2010 with the objective of increasing the percentage of Zimbabwean population who know their HIV status from 20% to 85% by year 2010 through expansion of HTC services. There has been a steady increase in the uptake of HTC services from 579 767 in year 2007 to 1 071 740 in year 2009(MOHCW 2010) Guidelines for HTC in Children were developed in 2008. Male Circumcision Strategy was launched in November 2009 as HIV/AIDS prevention Strategy.

CHAPTER 3.RESEARCH METHODOLOGY

Introduction

This chapter describes the research design, target population, sampling method, data collection and ethical consideration.

3.0 Research design

Research design is the outline plan, or strategy that specifies the procedure to be used in seeking an answer to research questions (Christensen et al 2011). A quantitative descriptive survey design was used in this research because it was conducted on a natural setting at three council clinics, MasvingoProvincial Hospital and one Private Clinic in Masvingo urban district.Masvingo Provincial Hospital has many departments which made it easier for me to get different types of health professionals. A descriptive survey describes what we see and examines relationship between variables only where there is adequate information. It is the best method for collecting original data and also excellent vehicle for the measurement of attitudes and orientation prevalent in a large population. The study was cross sectional.

3.1Target Population

The population was health professionals working at Masvingo Provincial Hospital, three council clinics and one private hospital in the Masvingo Urban District. These included nurses, doctors, laboratory scientists, pharmacists, pharmacy technician, physiotherapist, radiographers, primary counsellor and rehabilitation technician.

3.2 Sampling method

Simple Random sampling was be used to get health workers according to their professional disciplines. The sample was 40 health professionals broken down as follows, 21 Nurses, 3 Doctors, 2 Physiotherapist, 2 Pharmacist, 3 Pharmacy Technicians, 3 Radiographers, 3 Rehabilitation technicians and 3 Laboratory scientists .Doctors are only found at Masvingo Provincial hospital and Makurira Memorial clinic. Physiotherapist, Laboratory Scientist, Pharmacists, Pharmacy technicians, radiographers and Rehabilitation Technicians are only found at Masvingo Provincial Hospital. Nurses form the bulk of the health professionals. The participation was voluntary and health professional willing whowere on duty during the data collection period were given a chance to participate. The hat model of simple random was used on nurses who were in their departments. Their names were written on equal sized slips , put in a hat, shake the hat and the slips are picked until the required number of nurses for the sample were reached. This will be sampling without replacement.

3.3 Data Collection

Data collection from health profession was by means a self administered questionnaire. The questionnaires were distributed to the selected health professionals at Masvingo Provincial Hospital, Makurira Memorial Clinic and three council clinics the study sites. To ensure that a high proportion of questionnaires are returned, a time convenient to the health professionals was agreed upon and the researcherherself administered the questionnaires to the health professionals and collected the questionnaires immediately the health professionals completed them. The completed questionnaire were be kept in sealed envelopes by theinvestigator.

3.4 Ethical considerations

Ethical principles of autonomy, beneficence, non-maleficence, justice and trustworthiness to guided the study. An informed consent was obtained before administering the questionnaire and the health workers had the right to refuse to participate or withdraw from the research once participation has begun. The health professionals who participated in the study were informed that the study was anonymous where a coding system and not their names was used throughout data collection. Information collected from them was treated confidentially with no invasion of privacy, kept under lock and key cupboard and only used for the purpose it was collected for. The participants were told that they will be able to obtain information on nature, results and conclusions of the study. Permission to conduct the study was sought from the relevant hospital and clinics authorities and they were given the research proposal.

CHAPTER 4: DATA ANALYSIS AND PRESENTATION

Introduction

This chapter presents the research findings and various data representational techniques such as pie charts, bar graphs and tables will be used. Discussion of results will thus be made after analysis of results.

4.1: Demographic characteristics of respondents

4.1.1: Gender of respondents

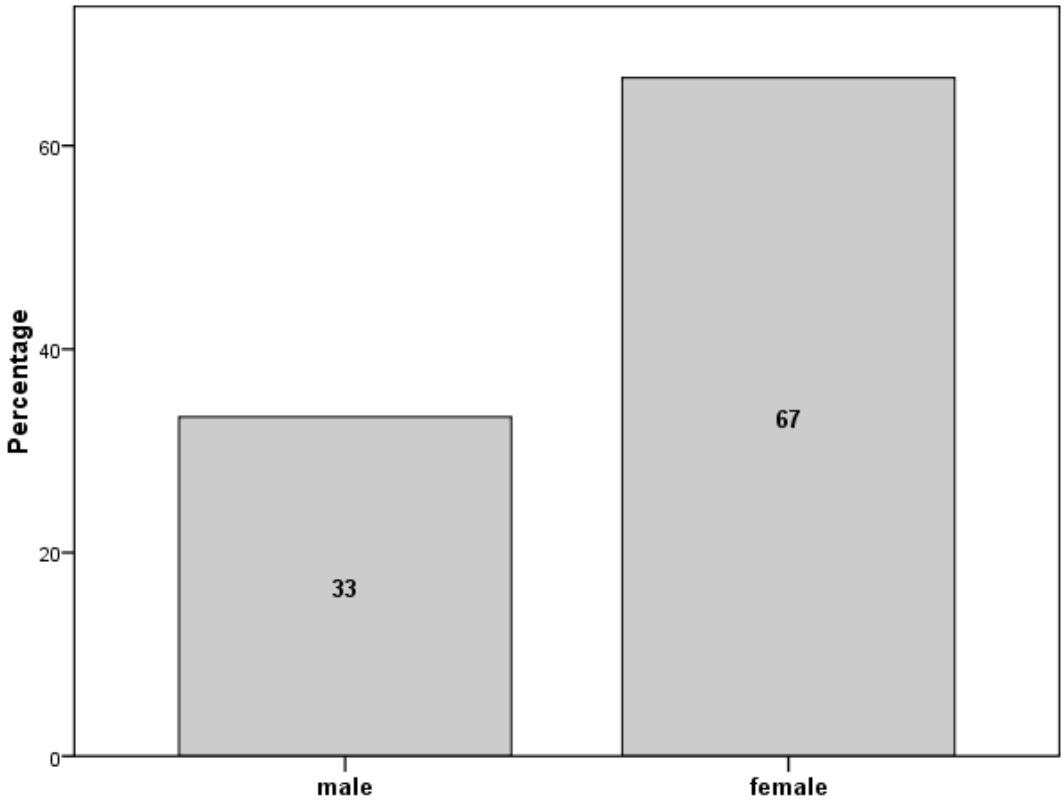

Figure 4.1: Gender of respondents

The gender of the respondents indicates that females dominated the respondents as they contributed 67% of the total whilst males only contributed 33% (Figure 4.1).

4.1.2 Age of respondents

From the research findings, it can be noted that the majority of the health workers were in the 45+ age group, contributing 42% of the respondents followed by the 36-45 age group which contributed 31% of the respondents as shown in Figure 4.2.

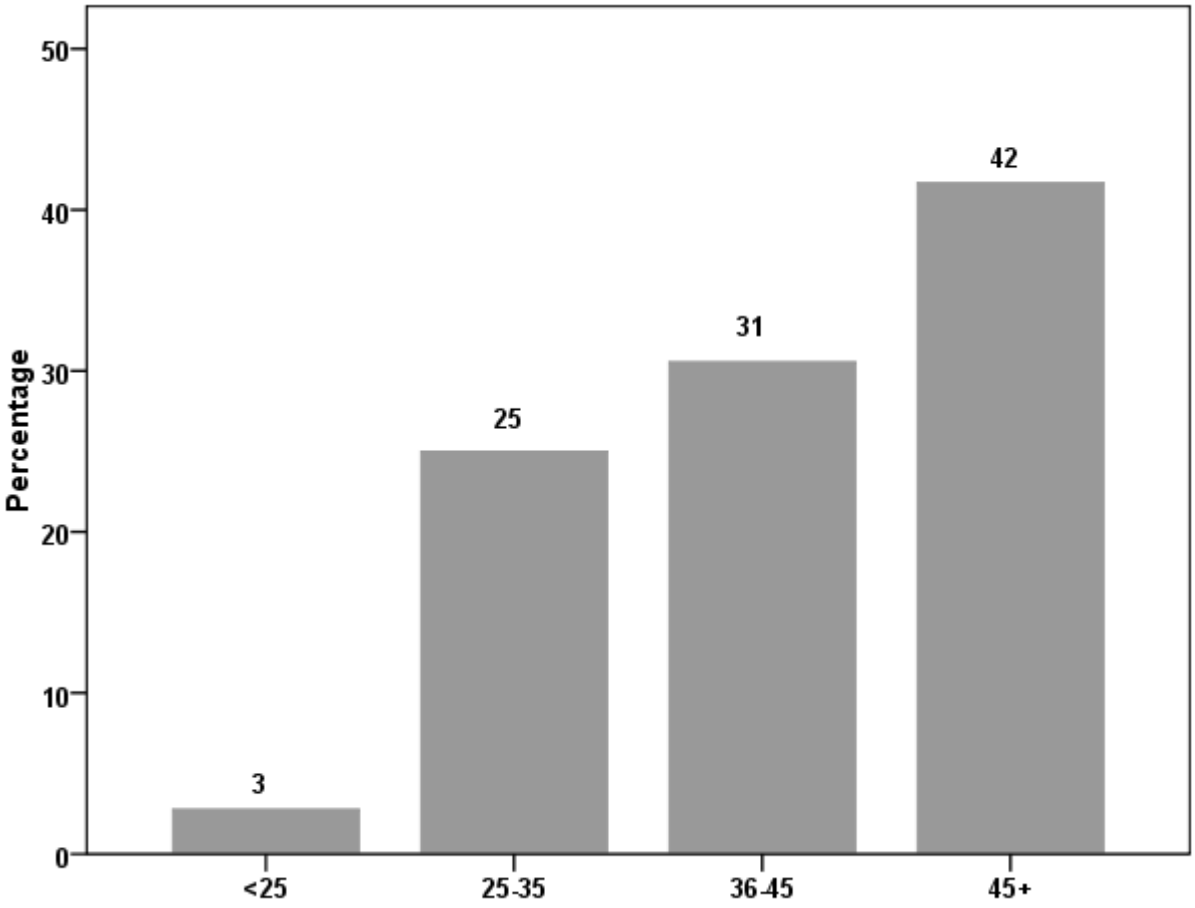

Figure 4.2: Age of respondents

4.1.3: Marital status of respondents

From the crosstab (gender and marital status) it can also be seen that in the married group, females contributed 62% whilst 38% where males, more females were single (75%) as compared to males (25%) and amongst the widowed and those who separated only females contributed (100%).

Table 4.1: Crosstab of gender and marital status

Marital status	Gender (%)	
	male	female
Single	25.0	75.0
Married	37.9	62.1
Separated		100.0
Widowed		100.0

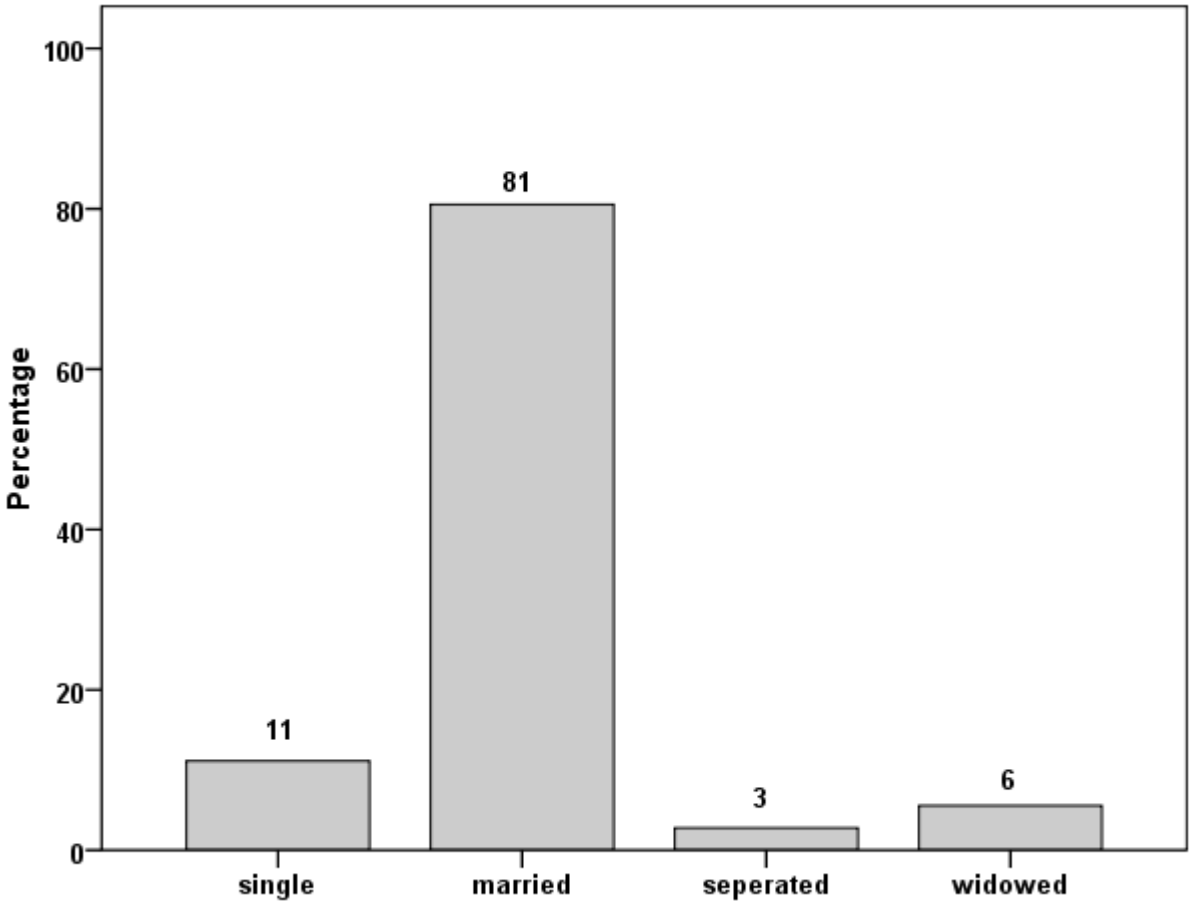

Figure 4.3: Marital status of respondents

4.1.4 Educational background

The health workers had academic qualifications including O' and A' level, with the majority of respondents (67%) having O' level and the remainder (33%) being A' Level graduates (Figure 4.4).

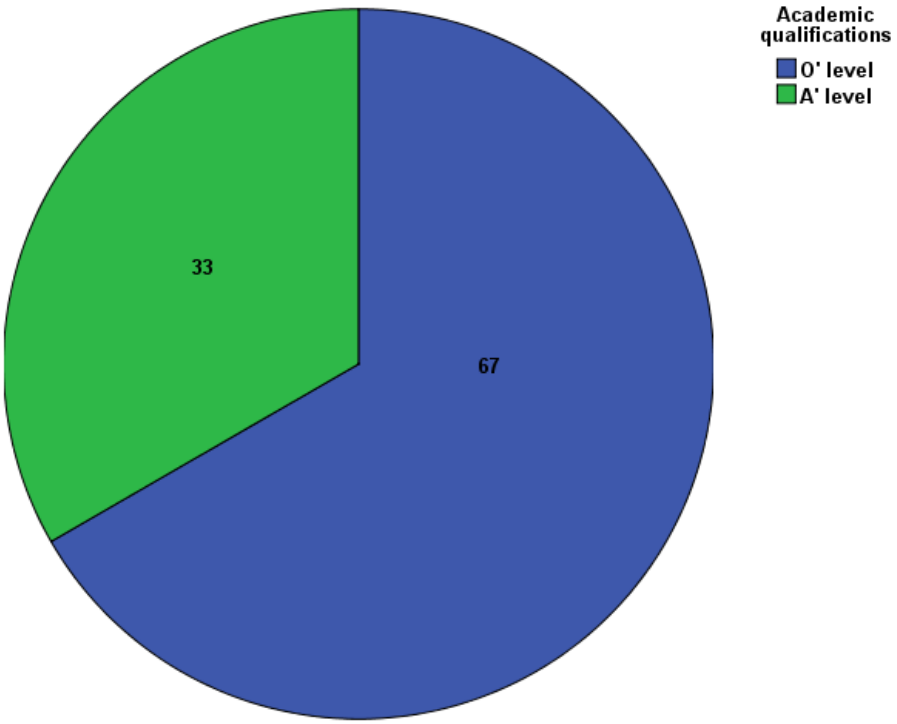

Figure 4.4: Academic qualifications of respondents

Table 4.2: The proportions of respondents according to their professions

Profession	Percentage of respondents
Doctor	8.3
Nurse	72.2
LaboratoryScientist	2.8
Pharmacy technician	2.8
Physiotherapist	2.8
Radiographer	2.8
Rehabilitation technician	5.6
Primary counsellor	2.8

From Table 4.2 it can be noted that, the majority of the respondents were in the nursing profession (72%), whilst Laboratory Scientist, Primary counsellor, Radiographer, Physiotherapist and Pharmacy technicians contributed the least number of respondents contributing 2.8% of the total respondents each. Nurses contributed the bulk of the respondents since the sampled placeswere a hospital and clinics whose priority service is the treatment of patients.

4.1.5 Work experience of the respondents

Work experience of the workers was mainly in the 21+ years range (47%), followed by the 6-10years and 16-20 years groups which had 17% each. This may be due to the fact that a number of the professionals are older than 45 years of age (Figure 4.2).

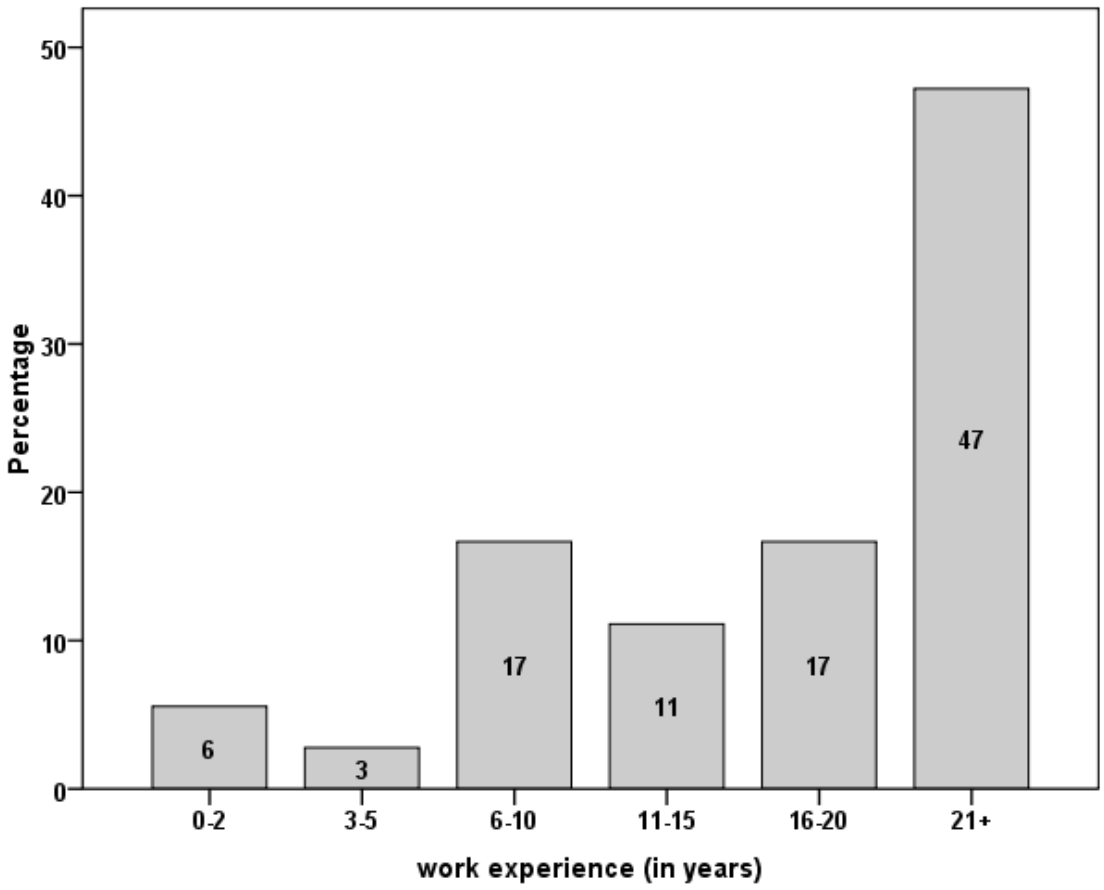

Figure 4.5: work experience of the health workers

4.2: Knowledge of health professionals on HIV and AIDS.

All the health professionals who took part in the survey had knowledge of HIV and AIDS. This maybe so because of the fact that many of the respondents had a sound educational background (O' level and A' level) as well as professional qualifications ranging from certificates, diplomas and degrees. When prompted to explain the differences further, the majority of the respondents (92%) went on to describe HIV as the virus that causes AIDS and 39% described HIV as the presence of the virus in the blood. A small proportion of the respondents (19%) described AIDS as a combination of diseases while 53 % described it as an advanced stage of HIV infection. Table 4.3 shows the health workers understanding of HIV and AIDS.

Table 4.3: Definitions of HIV and AIDS given by the respondents

Understanding of HIV/ AIDS	**Percentage**
HIV as the virus that causes AIDS	92
HIV as the presence of the virus in the blood	39
HIV as asymptomatic	3
AIDS as a combination of diseases	19
AIDS as the advanced stage of HIV infection	53
AIDS as a group of signs and symptoms	36
AIDS as a condition that weakens the body to fight infections	33

4.2.1: Familiarity with the modes of Transmission of HIV

To the health workers, unprotected sex with an infected partner and mother to child transmission were the most familiar methods of HIV transmission, with all the respondents (100%) citing each of them as familiar methods of HIV transmission. The rest of the methods were equally familiar to the health workers, with 86% of the respondents in each case citing familiarity with each method (Table 4.4).

Table 4.4: The modes of transmission of HIV and their familiarity to health workers

Mode of transmission of HIV	Percentage
Unprotected Sex	100
Mother to child transmission	100
Transfusion of unscreened blood	86
Sharing razor blades	86
Sharing needles and syringes for injection	86

The majority of the respondents (97%) believed that the correct and consistent use of condoms prevents HIV transmission that they can actually abstain from sex (97%) and that there is need to use condoms when both partners are infected with HIV (100%). This shows a generally high awareness on the transmission and prevention of new infections and re-infections.

4.3: The practice of HIV Testing and counselling

All the respondents were aware of a centre where one can access HIV testing and counselling services. The New Start Centre was the most popular HIV testing and counselling centre, with 70% of the respondents acknowledging its existence. A number of other small centres were cited as providing HIV testing and counselling (Table 4.5).

Table 4.5: Names of centres that provide HTC, which are familiar to health workers

Name of centre	Percentage of respondents
Masvingo Provincial Hospital	2.8
4 Brigade HTC	2.8
Gweru New Start Centre	2.8
Masvingo Provincial Hospital	11.1
Masvingo Urban Centre	2.8
New Start Centre	69.5
Rujeko Clinic	8.3
This Centre	2.8
Total	100.0

All the respondents knew what HIV testing and counselling is, although a number of explanations were given when they were prompted further for an explanation. The most popular explanation for HIV testing and counselling was that it is a procedure for preparation and familiarization with testing (83%), while others viewed it as a pre-test group education (42%). 44 % of the respondents viewed HIV counselling and testing as a post test counselling method (Table 4.6).

Table 4.6: Health workers understanding of HTC

Explanation of HTC	**Percentage of respondents**
Procedure for preparation and familiarization with testing	83
Pre-test group education	42
Sample of blood collected	67
Client gets the results	56
Post test counselling	44
Referral	17

A number of factors were listed as the benefits of HTC. These ranged from the empowerment of those not infected to protect themselves (97%) to assisting those infected to live positively (86%). Table 4.7 gives a summary of the cited benefits of HTC.

Table 4.7: The benefits of HTC cited by respondents

Benefits of HTC	**Percentage of respondents**
Empowers those still not infected to protect themselves from becoming infected with HIV.	97
Assist the infected to protect others and live positively	86
Enhances faithfulness	89
Prevention of mother to child transmission of HIV	89

The majority of the health workers (94%) went for an HIV test while the remainder had never been tested because they claimed they had never given it a thought. For those who were tested, a number of reasons were given as to why they went for HTC. These ranged from simply wanting to know their HIV status (83%) to it being part of the preparations for marriage (6%). Figure 4.6 gives a breakdown of the reasons given:

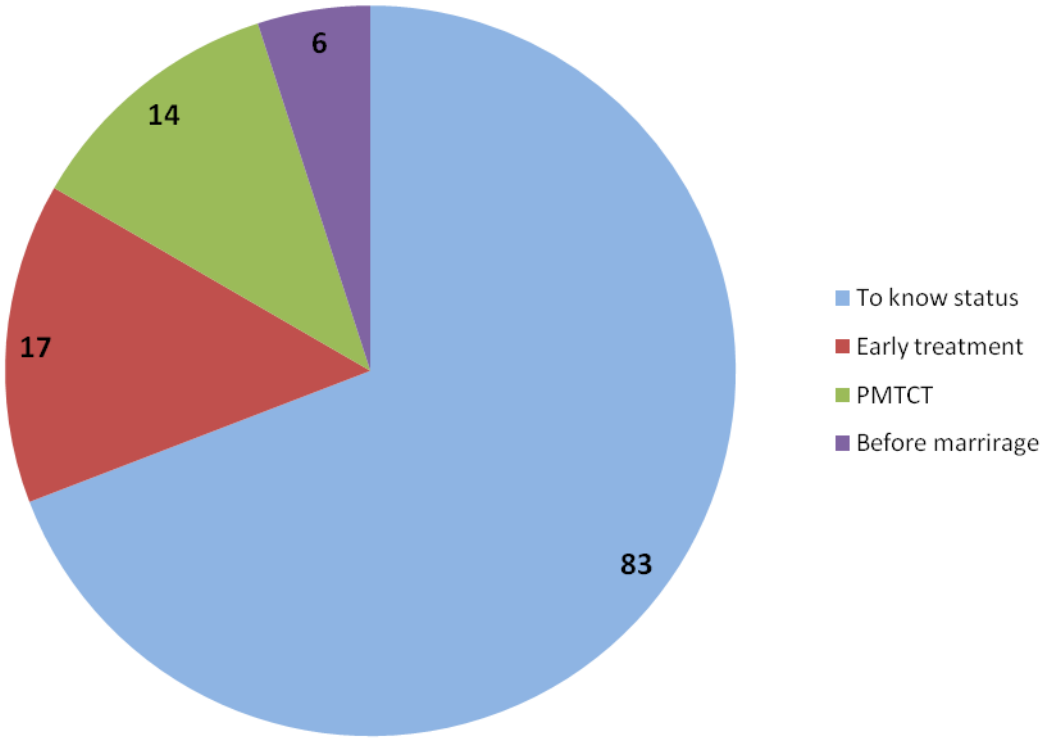

Figure 4.6: The reasons for going for HIV testing and counselling.

A minority of the health workers (31%) recalled that the HTC exercise was a frightening experience. The fear was mainly attributed to either a general fear of the unknown (19%) or the fear that gripped them when they were waiting for their HIV test results (14%).

The majority of the respondents (70%) cited that both counselling and testing were provided at HIV Testing and Counselling (HTC), while only 6% believed only counselling was offered, and 25% believe that only testing is available at an HTC centre. 86% of the

respondents agreed that there is use of code names and code numbers at HTC centres. These were observed to be mainly for reasons of confidentiality (56%) or anonymity (33%).

Eighty-one percent of the respondents were aware of the HIV tests done at HTC centres. 92% of the respondents went through the counselling and testing procedure and collected their results. The majority of the respondents got tested at the New Start Centre (39%), while other centres were also cited (Table 4.8).

Table 4.8: Names of centres where the respondents received HTC

Name of centre	**Percentage of respondents**
Chrome Mine Hospital	2.8
Gweru,Shurugwi	2.8
Masvingo Provincial Hospital	25.0
Mutare	2.8
New Start Centre	38.9
New Start Centre, UBH	2.8
Not applicable	11.1
Rujeko Clinic	5.6
South Africa	2.8
ZAPSO	5.6

Seventy five percent of the respondents knew the HIV status of their partners, 97% of the respondents believed that it is possible for a couple to have different results and 97% said that they would encourage workmates to get tested.

4.4: Attitudes of health professionals towards HTC

Fifty percent of the respondents indicated that their workmates will gossip about them if they were to test positive, while only 19% believed that their workmates will not gossip about them. 25% of the respondents indicated that they will be embarrassed if they their workmates discovered that they are HIV positive, 14% believed that the communities they work in will discriminate against them if they test HIV positive. The majority (75%) of the respondents indicated that they are able to share and discuss their HTC experiences with their partners, while 78% of the respondents reported that they are able to disclose their HIV status to their partners and family. 17% of the respondents said that there are possibilities of their partners leaving them if they are HIV positive, while 11% believed that it is not necessary for married couples to undergo HTC. A small fraction of the respondents (8%) have no confidence in HTC because they think the people who test them will disclose their HIV status to other people, or that the testing kits may give wrong results (11%). Only 8% said that they do not have time to go for HTC. The majority of the respondents (75%) believed that health professionals should be role models in HTC, while 22% highlighted that HTC should be compulsory pre-employment.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5: Introduction

Conclusions and recommendations are presented it this Chapter as well as the recommendations from the research findings.

5.1: Conclusions

The findings from this study provide some basic information on the uptake of HTC among thehealth professionals in Masvingo District. A majority of the health workers showed that they have knowledge of HTC, have a relatively high level of HTC uptake and can locate where the services are offered.

There are limitations with this kind of study and as such be caution should be taken when interpreting these findings as they were only taken at only three workplaces. As such caution should also be exercised before generalizing the study results to other workplaces, demographic and geographic regions.

5.2: Recommendations

Since the project was done on a relatively smaller population of Masvingo Urban, the idea should be expanded to encompass health professionals from other areas. There is also need for continuous education on the current dynamics on HIV and AIDS through advertisements and there should be follow-ups and refresher courses on the people educated to equip them with the latest knowledge.

Research is also needed to explore additional barriers to HTC uptake which include the possible stigmatization associated with post-HTC period in the event that a health

professional has been tested HIV positive. In addition, some ground has to be covered to ensure that people have confidence in the counsellors.

Finally, health care providers as health educators should play a dominant role in safeguarding the health of the community by encouraging the rehabilitation and integration of people already infected with the virus within the context of their families and the society as well as preventing the transmission of HIV. They should also be at the forefront of undergoing HTC, and explaining the benefits and advantages to the communities they operate in.

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Addendum A

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

WHAT ARE THE REASONS CONTRIBUTING TO LOW UPTAKE OF HIV TESTING AND COUNSELLING SERVICES BY HEALTH WORKERS IN MASVINGO URBAN DISTRICT?

You are asked to participate in a research study conducted by Namatirai Nyahwa, a Masters of Philosophy in HIV/AIDS Management Student from Africa Centre of HIV/AIDS Management, at Stellenbosch University in South Africa. You were selected as a possible participant in this study because the study is targeting health workers of all disciplines.

1. PURPOSE OF THE STUDY

To determinethe reasons contributing to low uptake of HIV Testing and Counseling services by Health workers in Masvingo Urban District.

2. PROCEDURES

If you volunteer to participate in this study, I would ask you to do the following things:

2.1 To read through the informed consent.

2.2 And if agreeable you sign the consent.

2.3 Complete the questionnaire and hand it back to the researcher Namatirai Nyahwa.

2.4 The questionnaire can be completed during your own spare time.

3. POTENTIAL RISKS AND DISCOMFORTS

There may be potential risks and discomfort in the form of emotional distress during and after the study. If you experience discomfort in the form of emotional distress during and after the study you will be referred to the Hospital Counselor Ruth Zulu at Masvingo Provincial Hospital for counseling.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The body of knowledge generated could enhance Zimbabwe Ministry of Health and Child Welfare practice through integration of new knowledge into training and in-service programmes for employees, community and stakeholders.

5. PAYMENT FOR PARTICIPATION

There will be no payment for participating in the research. Participation in the study is voluntary.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of use of code numbers and not names. Information collected from them will be treated confidentially with no invasion of privacy, kept under lock and key

cupboard and only used for the purpose it was collected for.The results of the study will be given the authorities of the institutions for the participants to be able to access them. The Medical Superintendent of Masvingo Provincial Hospital will submit the results to the Provincial Medical Director for who will pass them to Zimbabwe Ministry of Health and Child Welfare

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the following,

Namatirai Nyahwa: Principal Investigator cell 263 712 866 518 / email nnyahwa@gmail.com

or

Prof Johan Augustyn: The SupervisorTelephone +27 21 808 3002 / email jcda@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT

The information above was described to *me/the participant* by Namatirai Nyahwain *English/ Shona* and *I am* in command of this language. *I the participant* was jgiven the opportunity to ask questions and these questions were answered to *my* satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____Name of Participant

____N/A_____

Name of Legal Representative (if applicable)

_____ _____

Signature of Participant or Legal Representative Date

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of the participant]* . *[H*e/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [**English/Shona*] and *no translator was used.*

_ _____

Signature of Investigator Date

Addendum B

QUESTIONNAIRE

SECTION 1

Socio – Demographic Data (please tick)

1. Sex

Male ☐

Female ☐

2. Age in years

Less than 25 years ☐

25 – 35 years ☐

36 – 45 years ☐

over 45 years ☐

3. Marital status Single ☐

Married ☐

Divorced ☐

Separated ☐

Widowed ☐

Living together ☐

4. Academic qualifications

ZJC ☐

'O' LEVEL ☐

'A' LEVEL ☐

5. Professional qualification

Certificate	☐
Diploma	☐
Degree	☐

6. Professio0nal Discipline

Doctor	☐
Nurse	☐
Laboratory scientist	☐
Pharmacist	☐
Pharmacy Technician	☐
Physiotherapist	☐
Radiographer	☐
Rehabilitation Technician	☐

7. Work Experience in years

Up to 2 years	☐
3 to 5	☐
6 to 10	☐
11 to 15	☐
16 to 20	☐
Above 21	☐

SECTION 2

Knowledge of HIV/AIDS

(Please circle your answer)

1. Do you know the difference between HIV and AIDS? Yes / No

Please explain your answer.

……

……

2. Of the following modes of transmission of HIV which ones are you familiar with?

1) Unprotected sex .	
2) Mother to Child transmission.	
3) Transfusion of unscreened blood.	
4) Sharing razor blades.	
5) Sharing needles and syringes for injection.	

3. When a condom is used correctly and consistently does it prevent HIV infection? Yes / No

4. Is it possible to abstain from sex? Yes /No

5. Is there need to use condoms when both partners are HIV positive? Yes / No

SECTION 3

The practice of HIV Testing and Counselling

(Please circle or tick)

1. Do you know where to find HIV Testing & Counselling (HTC) Centres? Yes / No

If yes name one HTC centre……

……

2. Do you know what is HIV Testing & Counselling? Yes / No

If yes explain …….

……

3. Do you think the following are the benefits of HIV Testing & Counselling?

1. Empowers those still not infected to protect themselves from becoming infected with HIV.	
2. Assists infected to protect others and live positively.	
3. Supports safer relationships.	
4. Enhances faithfulness.	
5. Prevention of mother to child transmission of HIV.	

4. Have you ever been tested for HIV? Yes / No

If know why?.....

……

If yes what were the reasons for getting tested for HIV?.....

……

5. Did you find the HTC experience frightening? Yes / No

If yes why?.....

.....……..……

6.What are the type of services given at HTC centre? a. **Counselling only**, b. **Counselling and Testing**, c. **Both**

7. Do they use code names and code numbers at HTC centres? Yes / No

If yes why? Confidentiality or Anonymity

8. Do you know the type of HIV tests that are done at HTC centres? Yes / No

If yes which ones ……

9. Did you receive your HIV test results? Yes / No

10. Where did you get tested for HIV?……

11. Do you know the HIV status of your spouse/partner? Yes / No

12. Is it possible for a couple to have different HIV test results? Yes/No

13. Would you encourage workmates to get tested for HIV? Yes/ No

SECTION 4

Attitudes towards HIV Testing and Counselling

Please give your opinion

On a scale of1 to 5 please tick whether you

1 -strongly disagree, 2-disagree, 3-neutral, 4-agree, 5-strongly agree

1.My workmates would talk about me if I test HIV positive……1 2 3 4 5

2.My workmates would not talk about me if I test HIV positive……..1 2 3 4 5

3. I would be embarrassed if my workmates discover that I am HIV positive……1 2 3 4 5

4.The community I work in would discriminate me if I test HIV positive……...1 2 3 4 5

5.I am able to discuss with my partner about my HIV Testing &Counselling experiences……1 2 3 4 5

6.I can disclose my HIV status to my partner and family……1 2 3 4 5

7. If I disclose my HIV status to my partner there are possibilities of him/her leaving me if I am HIV positive…….....1 2 3 4 5

8. It is not necessary for married couple to go for HIV Testing & Counselling……1 2 3 4 5

9. I do not trust the person who tests me for HIV because they may tell people about my HIV test results……...1 2 3 4 5

10. I do not get time to go for HIV Testing and Counselling……1 2 3 4 5

10.HIV test Kits may give wrong results……..1 2 3 4 5

11. Health professionals should be role models in VCT of HIV / AIDS……..1 2 3 4 5

12. HIV testing & Counselling should be made compulsory pre- employment……1 2 3 4 5

Addendum C

Telephone : +263-39-262112/4
Fax : +263-39-264325

ZIMBABWE

Reference :
E C No:.
MINISTRY OF HEALTH & CHILD WELFARE
Masvingo Provincial Hospital
Office of the Medical Superintendent
P O Box 114
MASVINGO

26th November 2012

Mrs Namatirai Nyahwa
Masvingo New Start Centre
10 Hofmeyer Street
MASVINGO

Re : **PERMISSION TO CONDUCT RESEARCH AT MASVINGO PROVINCIAL HOSPITAL ON REASONS FOR LOW UPTAKE OF HIV TESTING & COUNSELLING SERVICES : BETWEEN DECEMBER 2012 & JANUARY 2013**

Thank you for your letter dated 1st July 2012.

Permission is hereby granted to carry out your research on Reasons for Low Uptake of HIV Testing and Counselling Services by Health workers at Masvingo Hospital.

Results of the research study will be shared with the institution

MEDICAL SUPERINTENDENT
MASVINGO PROVINCIAL HOSPITAL
26 NOV 2012
PO BOX 114, MASVINGO
ZIMBABWE TEL 039-262184

DR J CHIRENGWA
A/MEDICAL SUPERINTENDENT
researchcorresp:261112

Addendum D

MAKURIRA MEMORIAL CLINIC

TELEPHONE+263-39-263460/264919
FAX: +263-39-65781
CELL: 0773 397 731
Email makuriramemorialclinic@yahoo.com

psmakurira@yahoo.com

07 HOFMEYER STREET
P O BOX 465
MASVINGO
ZIMBABWE

23 July 2012

Mrs Namatirai Nyahwa

Masvingo New Start Centre

10 Hofmeyer Street

MASVINGO

Dear Madam

REF: PERMISSION TO CONDUCT A RESEARCH AT MAKURIRA MEMORIAL CLINIC

Thank you for your request to interview health care professionals at Makurira Memorial Clinic as part of your research project in pursuit of the Masters of Philosophy in HIV and AIDS Management with Stellenbosch University

Permission is hereby granted for you to carry out study your at Makurira Memorial Clinic..

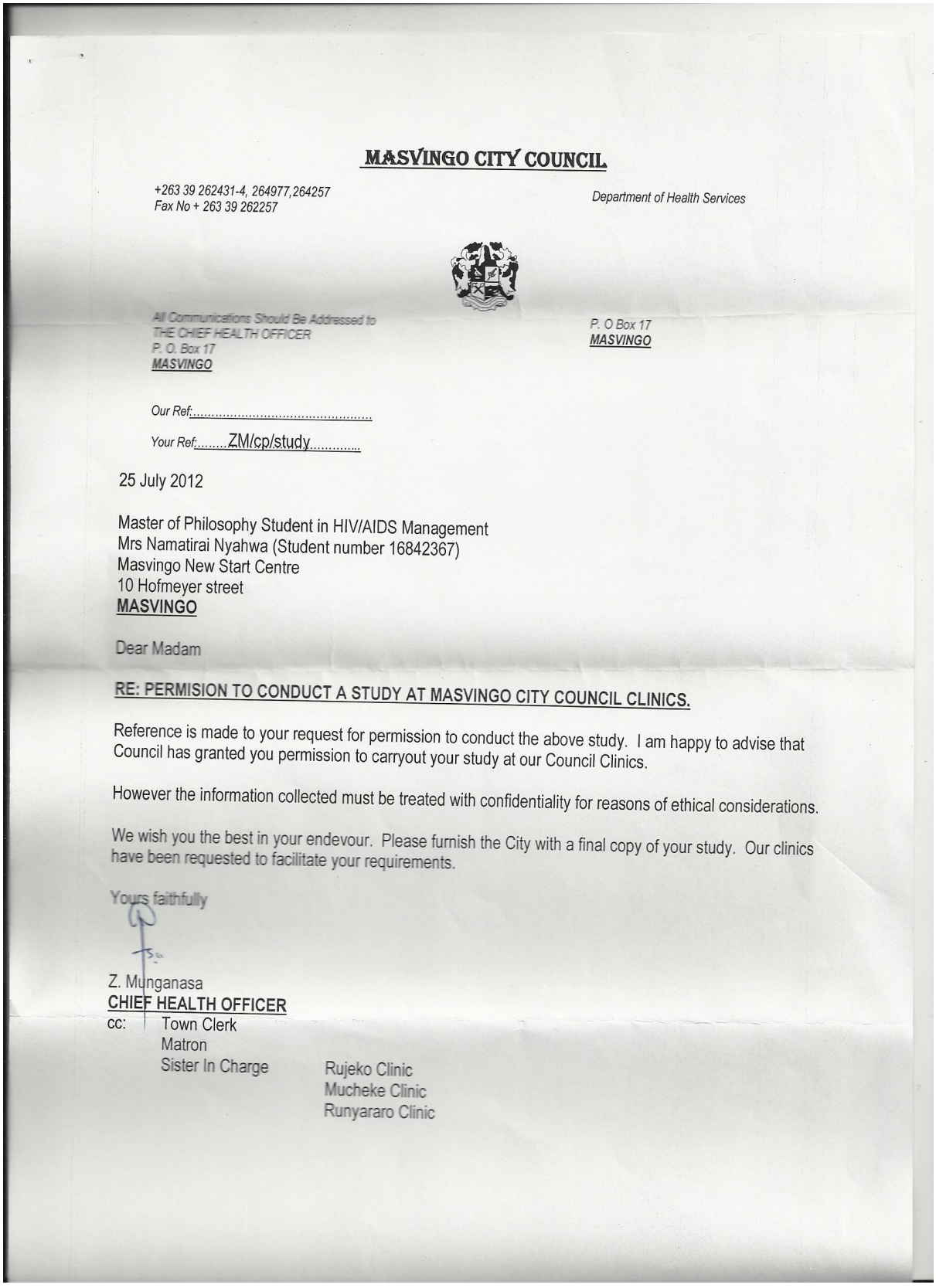
Yours sincerely

DR P S MAKURIRA

cc Dr B Mandishona

DR. P.S. MAKURIRA SURGERY
P.O. BOX 465
MASVINGO

Addendum E



MASVINGO CITY COUNCIL

+263 39 262431-4, 264977,264257
Fax No + 263 39 262257

Department of Health Services

All Communications Should Be Addressed to
THE CHIEF HEALTH OFFICER
P. O. Box 17
MASVINGO

P. O Box 17
MASVINGO

Our Ref:.....

Your Ref:.....ZM/cp/study.....

25 July 2012

Master of Philosophy Student in HIV/AIDS Management
Mrs Namatirai Nyahwa (Student number 16842367)
Masvingo New Start Centre
10 Hofmeyer street
MASVINGO

Dear Madam

RE: PERMISION TO CONDUCT A STUDY AT MASVINGO CITY COUNCIL CLINICS.

Reference is made to your request for permission to conduct the above study. I am happy to advise that Council has granted you permission to carryout your study at our Council Clinics.

However the information collected must be treated with confidentiality for reasons of ethical considerations.

We wish you the best in your endevour. Please furnish the City with a final copy of your study. Our clinics have been requested to facilitate your requirements.

Yours faithfully

Z. Munganasa
CHIEF HEALTH OFFICER
cc: Town Clerk
Matron
Sister In Charge

Rujeko Clinic
Mucheke Clinic
Runyararo Clinic